

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b x near - Rock Hall	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Co. Hospital		/d. STREET ADDRESS RFD * Skinner's Neck	
3. NAME OF DECEASED (Type or print) First Middle Last James H. Boulter		4. DATE OF DEATH Month Day Year June 23, 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/79
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman (fishinf & etc.)		10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward Boulter		14. MOTHER'S MAIDEN NAME Elizabeth Ashley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. Mrx. John Boulter - Rock Hall, Md.	
17. INFORMANT Mrx. John Boulter - Rock Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Cardio Vascular Disease 422.1 DUE TO with Advanced Congested Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 2 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/21 19 59 to 6/23 19 59 that I last saw the deceased alive on 6/23 19 59 , and that death occurred at 8 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 6/25/59			
ACTUAL SIGNATURE Robert W. Farr		M.D. Chestertown, Md.	
PHYSICIAN'S NAME (Type) Robert W. Farr			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 6/25/59	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel	22d. LOCATION (City, town, or county) (State) nr. Rock Hall, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Wells Wells		24a. REC'D BY REGISTRAR DATE JUN 29 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See also p. 10

1. Name of deceased (Print or write full name)

2. Sex

3. Date of birth

4. Place of birth (City, State, and Country)

5. Date of death

6. Time of death

7. Cause of death (Immediate)

8. Cause of death (Underlying)

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Signature of informant

13. Signature of funeral director

14. Signature of coroner

15. Signature of health officer

16. Signature of registrar

17. Signature of informant

18. Signature of funeral director

19. Signature of coroner

20. Signature of health officer

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06856

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Annes	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edward Henry Cain		4. DATE OF DEATH June 24 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 19, 1932
9. AGE (In years last birthday) 27 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		12. KIND OF BUSINESS OR INDUSTRY Farm	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? USA	
15. FATHER'S NAME Henry Cain		16. MOTHER'S MAIDEN NAME Erma Mae Stubbs	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		18. SOCIAL SECURITY NO. 215-36-134	
19. INFORMANT Hospital records, Chestertown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable hepatic toxemia and bile peritonitis 2 days 835x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture of liver (extensive), Avulsion of common bile duct from duodenum, & laceration of splenic pedicle (c) 2 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was thrown from tractor, and run over by disk harrow being pulled by the tractor.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. June 22, 59 1:30		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	
20e. (City or town) Ingle side		20f. (County) Queen Annes Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/27/59	
22c. NAME OF CEMETERY OR CREMATORY Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaie		ADDRESS Greensboro, Md.	
24a. REC'D BY REGISTRAR June 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME

RESIDENCE

AGE

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

SEX

EDUCATION

RELIGION

OCCUPATION

PROFESSION

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

PROFESSION

DATE OF DEATH

PLACE OF DEATH

REMARKS: (To be filled in by the medical examiner)

On the day of the month of the year, at the residence of the deceased, I examined the body of the deceased, who was found dead, and the cause of death was ascertained to be as follows:

The deceased was found dead, and the cause of death was ascertained to be as follows: (To be filled in by the medical examiner)

On the day of the month of the year, at the residence of the deceased, I examined the body of the deceased, who was found dead, and the cause of death was ascertained to be as follows:

The deceased was found dead, and the cause of death was ascertained to be as follows: (To be filled in by the medical examiner)

On the day of the month of the year, at the residence of the deceased, I examined the body of the deceased, who was found dead, and the cause of death was ascertained to be as follows:

6868

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>T</u> Last <u>CARROLL</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 24, 1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>E. M. Taylor</u>		14. MOTHER'S MAID NAME <u>Mrs. Sawyer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-09-6944</u>	
17. INFORMANT <u>George A. Taylor</u>		Address <u>Rock Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Liver</u> DUE TO (b) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>5/2/59</u> , 19____, to <u>6/25/59</u> , 19____, that I last saw the deceased alive on <u>6/16/59</u> , 19____, and that death occurred at <u>5:30</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William M. Gatewood</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, md</u> DATE SIGNED <u>6/26/59</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM GATEWOOD</u>		<u>ROCK HALL</u>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>6-27-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lowe</u> ADDRESS <u>Church Hill, md</u>		24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by filling in by the funeral director, TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1929

<p>NAME OF DECEASED <i>John Doe</i></p>		<p>AGE <i>45</i></p>	<p>SEX <i>Male</i></p>
<p>DATE OF DEATH <i>Jan 15 1929</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>	<p>PLACE OF DEATH <i>Home</i></p>
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PREVAILING DISEASE <i>Arteriosclerosis</i></p>		<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RELIGION <i>Methodist</i></p>		<p>US BIRTH <i>Yes</i></p>	
<p>DATE OF BIRTH <i>Jan 1 1884</i></p>		<p>PLACE OF BIRTH <i>Maryland</i></p>	
<p>DATE OF DEATH <i>Jan 15 1929</i></p>		<p>TIME OF DEATH <i>10:30 AM</i></p>	
<p>PLACE OF DEATH <i>Home</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>		<p>PREVAILING DISEASE <i>Arteriosclerosis</i></p>	
<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>		<p>EDUCATION <i>High School</i></p>	
<p>OCCUPATION <i>Teacher</i></p>		<p>RELIGION <i>Methodist</i></p>	
<p>US BIRTH <i>Yes</i></p>		<p>DATE OF BIRTH <i>Jan 1 1884</i></p>	
<p>PLACE OF BIRTH <i>Maryland</i></p>		<p>DATE OF DEATH <i>Jan 15 1929</i></p>	
<p>TIME OF DEATH <i>10:30 AM</i></p>		<p>PLACE OF DEATH <i>Home</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE <i>Myocardial Infarction</i></p>	
<p>PREVAILING DISEASE <i>Arteriosclerosis</i></p>		<p>PREVAILING SYMPTOMS <i>Angina Pectoris</i></p>	
<p>EDUCATION <i>High School</i></p>		<p>OCCUPATION <i>Teacher</i></p>	
<p>RELIGION <i>Methodist</i></p>		<p>US BIRTH <i>Yes</i></p>	
<p>DATE OF BIRTH <i>Jan 1 1884</i></p>		<p>PLACE OF BIRTH <i>Maryland</i></p>	



STATE OF MARYLAND
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

RECEIVED
JAN 16 1929
BUREAU OF VITAL STATISTICS
STATE OF MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
 TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6869

CERTIFICATE OF DEATH

06858

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD Worton				c. LENGTH OF STAY IN life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home				d. STREET ADDRESS RFD			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Oliver Middle Hyhson Last Hyhson				4. DATE OF DEATH Month June Day 9 Year 1959			
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30, 1888	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 1 Hours 1 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY various		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U SA	
13. FATHER'S NAME Elmore Hynson				14. MOTHER'S MAIDEN NAME Amanda Ringgold			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-16-5166		17. INFORMANT Anna Hynson		Address Worton, RFD Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute indigestion 544.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 5, 1959 , to June 9, 1959 , that I last saw the deceased alive on June 9, 1959 , and that death occurred at Rock Hall, Maryland , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Rock Hall, Maryland 6/10/59							
ACTUAL SIGNATURE E. Kester				M.D. Eugene Kester			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		22b. DATE THEREOF June 13 1959		22c. NAME OF CEMETERY OR CREMATORY Fountain Cem. (Bigwoods)		22d. LOCATION (City, town, or county) (State) Worton Md. RFD	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR DATE JUN 12 '59	
				24b. REGISTRAR'S SIGNATURE Carlton S. Kross			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6870 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06859

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Rock Hall c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY 02X-2 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS RFD 7 Box 377 D, Pasadena, e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First JAMES Middle REUBEN Last KARNS				4. DATE OF DEATH Found June 22 1959 Month June Day 22 Year 1959									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/25		9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 34 Days 0 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Wright				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.				11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Terrance Karns				14. MOTHER'S MAIDEN NAME Violet Widows				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII					
16. SOCIAL SECURITY NO. 220-16-6688				17. INFORMANT Violet Karns, Cumberland, Maryland				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 850x DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell out of boat.									
20c. TIME OF INJURY Month, Day, Year Hour XXX p. m. 6/17 1959				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bay		20f. (City or town) Rock Hall		(County) Kent		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <i>Charles S. Petty</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 6/23/59					
EXAMINER'S NAME (Type) Charles S. Petty, M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/26/59		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery				22d. LOCATION (City, town, or county) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc., Cumberland, Maryland						24a. REC'D BY REGISTRAR DATE JUN 29 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 532 Cannon St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH E. Middle LONG Last 		4. DATE OF DEATH Month June Day 17 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29 1922
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) Fairlee Kent Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S....	
13. FATHER'S NAME Charles Long		14. MOTHER'S MAIDEN NAME Sarah Hopkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. 201-03-1923	
17. INFORMANT Mrs. Eva Long		18. ADDRESS 532 Cannon St. Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 20 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1956 to June 17 1959 , that I last saw the deceased alive on June 17 1959 , and that death occurred at 11 A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 6/18/59			
ACTUAL SIGNATURE Robert W. Farr		M.D. Robert W. Farr, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/59	
22c. NAME OF CEMETERY OR CREMATORY Chestertown Cemetery		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ervin V. Williams		24a. REC'D BY REGISTRAR DATE JUN 23 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Francis			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06861

6871

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rock Hall			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Ethel Middle M. Last Nitsch				4. DATE OF DEATH Month June Day 27 Year 19 59			
5. SEX Fem.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19-1890	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	10. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Frank Katzenberger				14. MOTHER'S MAIDEN NAME Lillie Chalmers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, at unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Norbert Nitsch Jr. Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema & Uremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic Arteriosclerotic Cardio-renal Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 wks.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetic Gangrene Rt. Foot							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from MAY 10, 1959 to June 27, 1959 , that I last saw the deceased alive on June 27, 1959 , and that death occurred at 5 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED ACTUAL SIGNATURE Arthur T. Keefe M.D. PHYSICIAN'S NAME (Type) Arthur T. Keefe Chestertown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 30	22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar D. Lane			ADDRESS Church Hill, Md.		24a. REC'D BY REGISTRAR JUL 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

MONTANA STATE DEPARTMENT OF HEALTH - BATTLEBORE 19

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

EDUCATION

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RELIGION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RELIGION

DATE OF DEATH

PLACE OF DEATH

6867
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN TB 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hartly		46x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Pratt Last Waddell		4. DATE OF DEATH Month June Day 1 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/88
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm. H. Waddell		14. MOTHER'S MAIDEN NAME Annie McIlhinney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 195-05-8298	
17. INFORMANT Mrs. Margaret Waddell		Address Hartly, Dela.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Failure 456x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal insufficiency DUE TO (c) Pericarditis No Dosa.		INTERVAL BETWEEN ONSET AND DEATH 2 Days 2 months 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dishman for 17 Days		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/21 , 19 59 , to 6/1 , 19 59 , that I last saw the deceased alive on 6/1 , 19 59 , and that death occurred at 4:59 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Chestertown DATE SIGNED 6/1/59			
ACTUAL SIGNATURE Thomas J. Solon		M.D. Chestertown	
PHYSICIAN'S NAME (Type) Thomas J. Solon		Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/4/59	
22c. NAME OF CEMETERY OR CREMATORY Lawncroft Cem.		22d. LOCATION (City, town, or county) (State) Linwood, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Wilks Wilks		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE JUN 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE BRANCH COMPANY REGIMENT DIVISION CORPS SERVICE NUMBER GRADE BRANCH COMPANY REGIMENT DIVISION CORPS SERVICE NUMBER		PLACE OF DEATH DATE OF DEATH TIME OF DEATH CAUSE OF DEATH MANNER OF DEATH PLACE OF INTERMENT DATE OF INTERMENT TIME OF INTERMENT NAME OF FUNERAL HOME NAME OF MINISTER NAME OF CLERGYMAN NAME OF CHURCH NAME OF CEMETERY NAME OF FUNERAL HOME NAME OF MINISTER NAME OF CLERGYMAN NAME OF CHURCH NAME OF CEMETERY
SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF CLERGYMAN SIGNATURE OF MINISTER SIGNATURE OF CHURCH SIGNATURE OF CEMETERY SIGNATURE OF FUNERAL HOME SIGNATURE OF MINISTER SIGNATURE OF CLERGYMAN SIGNATURE OF CHURCH SIGNATURE OF CEMETERY SIGNATURE OF FUNERAL HOME		SIGNATURE OF DECEASED SIGNATURE OF WITNESSES SIGNATURE OF CLERGYMAN SIGNATURE OF MINISTER SIGNATURE OF CHURCH SIGNATURE OF CEMETERY SIGNATURE OF FUNERAL HOME SIGNATURE OF MINISTER SIGNATURE OF CLERGYMAN SIGNATURE OF CHURCH SIGNATURE OF CEMETERY SIGNATURE OF FUNERAL HOME

This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the State Department of Health, Baltimore, Maryland.
 It is to be filled out in duplicate, and the original is to be filed in the office of the State Department of Health, Baltimore, Maryland.
 The duplicate is to be filed in the office of the local health officer, and is to be filed in the office of the local health officer, and is to be filed in the office of the local health officer.